MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

March 9-10, 2006

Improving payment for clinical laboratory services

ISSUE: Spending for clinical lab services has increased considerably in the recent past. Since 1999, volume and intensity growth has caused Medicare expenditures for lab services to climb an average of 9 percent per year. Growth in volume can be expected to continue in future years, as the range and complexity of laboratory tests expands and innovations in laboratory equipment and techniques make some testing more efficient and automated. The growing use of clinical practice guidelines and advances in medical knowledge also continue to increase the use of screening and monitoring tests. Given the increased used of lab tests, it is important to determine how Medicare's payment methodology can be improved so as to make payments more accurate and better promote efficiency.

KEY POINTS: Medicare pays labs directly based on a fee schedule for tests performed in ambulatory settings: hospital-based labs, independent labs, and physician labs. To pay for clinical lab services, Medicare uses carrier-specific fee schedules. Payment rates were initially set separately for more than 1000 tests in each carrier's geographic market, based on what local labs charged in 1983. National payments limits are set at 74 percent of the median of all carrier fee schedule amounts for each service. In practice, most lab claims are paid at the national limits. Since 1997, payments have been updated only once, when a 1.1 percent update was applied in 2003. The MMA has frozen payments for clinical laboratory services through December 31, 2008.

ACTION: Staff seeks Commissioner input on the draft chapter.

STAFF CONTACT: Dana Kelley (202-220-3703); Ariel Winter (202-220-3755)